Report No. 97-19 December 1997

OVERVIEW

THE AUDITOR
STATE OF HAWAII

Study of Proposed Mandated Additional Mental Health and Alcohol and Drug Abuse Insurance Benefits

Summary

House Concurrent Resolution No. 18, House Draft 1, Senate Draft 1 of the 1997 legislative session requested the Auditor to assess the social and financial impact of mandating parity in mental health and substance abuse insurance coverage. House Bill No. 427 was introduced in the 1997 legislative session to mandate that insurance coverage for mental health and alcohol and drug abuse treatment be no less extensive than that provided for other medical illnesses. The current law mandating health insurance coverage for mental illness and substance abuse treatment insurance benefits is scheduled to sunset on July 1, 1998.

Mandated insurance coverage for mental health and substance abuse services is provided under Chapter 431M, Hawaii Revised Statutes, "Mental Health and Alcohol and Drug Abuse Treatment Insurance Benefits." Coverage for mental health and substance abuse services is also provided under Hawaii's workers' compensation and motor vehicle insurance laws. Under the current law, a wide variety of mental health and substance abuse services are presently available. Providers include psychiatrists, psychologists, advanced practice registered nurses, and clinical social workers.

House Bill No. 427 would amend Chapter 431M, HRS, by deleting the required benefits for inpatient hospital services, non-hospital, and outpatient mental health services, and alcohol and drug treatment and detoxification services. The proposed amendment would require benefits for mental health and substance abuse services be no less extensive than coverage provided for any other medical illness. It would put coverage for mental health and substance abuse services on par (or provide parity) with services provided for other medical illnesses.

Interest and momentum for parity in insurance coverage for mental health and substance abuse services follows Congress' enactment of the Mental Health Parity Act of 1996. Thus far, nine states have parity laws.

The lack of a definition of parity affects the assessment of H.B. 427. Depending on the insurance plan, there *are* limits on coverage for other medical illness services. These limits include the number of covered authorized visits, copayment provisions, types of services covered, and medical necessity of the service. Parity, then, would mean varying limits on mental health services—depending upon the individual insurance plan.

There is very limited information on the extent to which the lack of parity in coverage results in persons being unable to obtain necessary treatment. Currently, insurers and mental health advocates indicate that a small proportion of Hawaii's population is using mental health and substance abuse services. Of those, few reach their benefit maximums. Therefore, there appears to be adequate access to mental health services for members who use these services. For individuals with severe mental disorders, the lack of parity in mental health coverage may result in hardship under the current coverage.

In light of the low demand from employee groups, and low utilization under the coverage currently available, we conclude that mandating parity in coverage for all mental health and substance abuse services is not warranted at this time. Also, changing the law to define treatment in hours instead of visits might provide sufficient additional coverage.

Recommendations and Response

The Department of Health supports a process through which health insurance mandates are periodically and collectively reviewed. The department expects over the long term, parity in private insurance would allow patients to get treatment earlier and have a better chance of remaining employed and covered by private insurance. The department has concerns about the limited scope of our review. It questions whether parity is not warranted and whether hours of treatment instead of visits is a solution for outpatient treatment.

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